Elaine Davis, LPC, LMFT ***503-402-8654***

Marriage and Family Therapist

DavisElaineJ@gmail.com

3000 NW Stucki Pl. #230

Hillsboro, OR 97124

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION FORM

This form, when completed and signed by you, authorizes me to release protected information from your clinical record or authorizes another to release protected information to me.

I, _____ **AUTHORIZE:** Elaine Davis, LPC, LMFT

(Name of client)

_____ 3000 NW Stucki Pl Suite 230

(Street address)

_____ Hillsboro, OR 97124

(City, state, zip code)

to disclose/obtain the following information:

Please check information to be disclosed:

__ Drug and Alcohol Treatment
__ Psychiatric/Mental Health Treatment
__ Treatment Plans
__ Progress in Treatment
__ School Records
__ Assessment and Diagnosis
__ Evaluations
__ Entire Mental Health Record
__ Phone Consult
__ Other- Specify

_____

_____

From/To:

_____
(Name of individual/doctor/counselor/agency

_____
(Street address)

_____
(City, state, zip code

_____
(Phone number)

I understand that this information may be disclosed orally or in writing for 6 months after the date listed below. I also understand that my records are not herby subject to further disclosure without my written consent. I may revoke this authorization at any time by giving written notification to my provider. A revocation will not affect any action taken because of reliance on the authorization prior to the revocation.

_____ _____
(Signature of client) Date

_____ _____
(Signature of parent or guardian) Date